# Izadi & Szeto APDC

Practice Limited to Microscopic & Surgical Endodontics

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American Association of Endodontists
*Specialist Members*


**Appointment Information:**

The following time has been reserved specifically for you. If for any reason you must cancel your appointment, please notify us at least one (1) day in advance.

Today's Date: _____/_____/_____

Patient Name: _____ Age: _____ Gender: M / F

Patient Phone: _____

IMPORTANT: All patients under the age of 18 must be accompanied by a parent or a guardian at the consultation visit.

Tooth/Area: _____

Appointment Date: _____/_____/_____ Time: _____:_____ am / pm Day: M T W Th F S

Referred By: _____ Phone: _____

**Please check one or more of the following:**

1. ☐ Endodontic treatment
2. ☐ Endodontic retreatment
3. ☐ Surgical Endodontics
4. ☐ Treat as necessary
5. ☐ Post space only
6. ☐ Post build up
7. ☐ Endodontic bleaching
8. ☐ Endodontic consultation only (Do not start treatment)
9. ☐ Call me before start of treatment
10. ☐ Other

**Special instructions and/or comments:**

**Handicap assistance is available, please inform the receptionist when your appointment is scheduled